

General

Title

Palliative and end-of-life care: percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening.

Source(s)

National Quality Forum (NQF). Palliative and end-of-life care 2015-2016: technical report. Washington (DC): National Quality Forum (NQF); 2016 Dec 23. 209 p.

The Carolinas Center for Medical Excellence (CCME). Specifications for recommended quality measures. Cary (NC): The Carolinas Center for Medical Excellence (CCME); 8 p.

Measure Domain

Primary Measure Domain

Clinical Quality Measures: Process

Secondary Measure Domain

Does not apply to this measure

Brief Abstract

Description

This measure is used to assess the percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening.

Note: This quality measure should be paired with the [Pain Screening](#) quality measure to ensure that all patients who report pain are clinically assessed.

Rationale

This measure addresses pain for patients with high severity of illness and risk of death, including seriously and incurably ill patients enrolled in hospice or hospital-based palliative care. Research on care of patients with serious incurable illness and those nearing the end of life shows they experience high

rates of pain (40% to 70% prevalence) and other physical, emotional, and spiritual causes of distress ("A controlled trial," 1995; Gade et al., 2008). The National Priorities Partnership has identified palliative and end-of-life care as one of its national priorities. A goal of this priority is to ensure that all patients with life-limiting illness have access to effective treatment for symptoms such as pain and shortness of breath. The affected populations are large; in 2009, 1.56 million people with life-limiting illness received hospice care ("NHPCO facts and figures," 2010). In 2008, 58.5% of United States (U.S.) hospitals with 50 or more beds had some form of palliative care service, and national trends show steady expansion of these services ("Palliative care programs," 2010). Patients and family caregivers rate pain management as a high priority when living with serious and life-limiting illnesses (Singer, Martin, & Kelner, 1999). The consequences of inadequate screening, assessment and treatment for pain include physical suffering, functional limitation, and development of apathy and depression (Gordon et al., 2007).

Evidence for Rationale

A controlled trial to improve care for seriously ill hospitalized patients. The study to understand prognoses and preferences for outcomes and risks of treatments (SUPPORT). The SUPPORT Principal Investigators. JAMA. 1995 Nov 22-29;274(20):1591-8. [PubMed](#)

Gade G, Venohr I, Conner D, McGrady K, Beane J, Richardson RH, Williams MP, Liberson M, Blum M, Della Penna R. Impact of an inpatient palliative care team: a randomized control trial. J Palliat Med. 2008 Mar;11(2):180-90. [PubMed](#)

Gordon DB, Dahl JL, Miaskowski C, McCarberg B, Todd KH, Paice JA, Lipman AG, Bookbinder M, Sanders SH, Turk DC, Carr DB. American Pain Society recommendations for improving the quality of acute and cancer pain management: American Pain Society Quality of Care Task Force. Arch Intern Med. 2005 Jul 25;165(14):1574-80. [82 references] [PubMed](#)

NHPCO facts and figures: hospice care in America. [internet]. Alexandria (VA): National Hospice and Palliative Care Organization; 2010 Sep.

Palliative care programs continue rapid growth in U.S. hospitals becoming standard practice throughout the country. [internet]. New York (NY): Center to Advance Palliative Care; 2010 Apr 6.

Singer PA, Martin DK, Kelner M. Quality end-of-life care: patients' perspectives. JAMA. 1999 Jan 13;281(2):163-8. [PubMed](#)

University of North Carolina - Chapel Hill. National Quality Forum (NQF) measure submission and evaluation worksheet 5.0: Hospice and palliative care - pain assessment. 16 p.

Primary Health Components

Palliative care; end-of-life care; pain assessment

Denominator Description

Patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting who report pain when pain screening is done on the admission evaluation/initial encounter (see the related "Denominator Inclusions/Exclusions" field)

Numerator Description

Patients who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain (see the related "Numerator Inclusions/Exclusions" field)

Evidence Supporting the Measure

Type of Evidence Supporting the Criterion of Quality for the Measure

A clinical practice guideline or other peer-reviewed synthesis of the clinical research evidence

A systematic review of the clinical research literature (e.g., Cochrane Review)

One or more research studies published in a National Library of Medicine (NLM) indexed, peer-reviewed journal

Additional Information Supporting Need for the Measure

Pain is prevalent and undertreated for many populations of seriously ill patients, including those patients nearing the end of life. Poor screening, assessment, and undertreatment of pain is more common for patients with serious illness who are also of minority race ethnicity. Use of the Pain Screening and Pain Assessment quality measures will increase reporting and efforts to improve awareness of the presence of pain (screening) and assessment of severity, etiology and effect on function (assessment) which are the essential first steps required for quality pain management and treatment.

Pain is prevalent, underdiagnosed and undertreated in cancer and other life-limiting or serious illnesses. The prevalence of pain ranges from 40% to 80% in seriously ill patient populations. As detailed in a systematic review from the Agency for Healthcare Research and Quality (AHRQ) and the American Pain Society Quality of Care guidelines, pain screening and assessment are the essential steps required to ensure that pain is detected by clinicians and appropriate treatment implemented (Wells, Pasero, & McCaffery, 2008; Gordon et al., 2005). Failure to screen, assess, and treat pain results in functional limitations, physiologic stress, and psychological harms such as social withdrawal and depression.

The current quality of pain screening, assessment, and treatment is poor, as documented in systematic pain prevalence and treatment studies from hospital, outpatient, cancer and nursing home settings (Reynolds et al., 2002; Deandrea et al. 2008; Mularski et al., 2006; Erdek & Pronovost, 2004). In a systematic review of quality of pain care for diverse patient populations, Gordon reported high average pain severity (6.17 to 8.37 on 10-point scale) and moderate rates of pain severity screening or other assessment (47% to 96%). These findings did not vary by underlying diagnosis (Gordon et al., 2002).

Extensive evidence documents disparities in cancer pain treatment and control (Pletcher et al., 2008; Green, Montague, & Hart-Johnson, 2009). Nursing home residents with advanced cancer receive less effective pain treatment if they are African American (Bernabei et al., 1998; Engle, Fox-Hill, & Graney, 1998). The Eastern Cooperative Oncology Group Minority Outpatient Pain Study enrolled 1308 patients with advanced cancer. After clinic visits, physicians underestimated pain severity for 64% of Hispanic and 74% of African American patients (Anderson et al., 2000). Among patients with pain, 65% of Hispanic and African American patients received inadequate treatment relative to practice guidelines, as did 50% of white patients (Cleeland et al., 1997; Cleeland et al., 1994).

Evidence for Additional Information Supporting Need for the Measure

Anderson KO, Mendoza TR, Valero V, Richman SP, Russell C, Hurley J, DeLeon C, Washington P, Palos G, Payne R, Cleeland CS. Minority cancer patients and their providers: pain management attitudes and practice. *Cancer*. 2000 Apr 15;88(8):1929-38. [PubMed](#)

Bernabei R, Gambassi G, Lapane K, Landi F, Gatsonis C, Dunlop R, Lipsitz L, Steel K, Mor V. Management of pain in elderly patients with cancer. SAGE Study Group. Systematic Assessment of Geriatric Drug Use via Epidemiology. JAMA. 1998 Jun 17;279(23):1877-82. [PubMed](#)

Cleeland CS, Gonin R, Baez L, Loehrer P, Pandya KJ. Pain and treatment of pain in minority patients with cancer. The Eastern Cooperative Oncology Group Minority Outpatient Pain Study. Ann Intern Med. 1997 Nov 1;127(9):813-6. [PubMed](#)

Cleeland CS, Gonin R, Hatfield AK, Edmonson JH, Blum RH, Stewart JA, Pandya KJ. Pain and its treatment in outpatients with metastatic cancer. N Engl J Med. 1994 Mar 3;330(9):592-6. [PubMed](#)

Deandrea S, Montanari M, Moja L, Apolone G. Prevalence of undertreatment in cancer pain. A review of published literature. Ann Oncol. 2008 Dec;19(12):1985-91. [47 references] [PubMed](#)

Engle VF, Fox-Hill E, Graney MJ. The experience of living-dying in a nursing home: self-reports of black and white older adults. J Am Geriatr Soc. 1998 Sep;46(9):1091-6. [PubMed](#)

Erdek MA, Pronovost PJ. Improving assessment and treatment of pain in the critically ill. Int J Qual Health Care. 2004 Feb;16(1):59-64. [PubMed](#)

Gordon DB, Dahl JL, Miaskowski C, McCarberg B, Todd KH, Paice JA, Lipman AG, Bookbinder M, Sanders SH, Turk DC, Carr DB. American Pain Society recommendations for improving the quality of acute and cancer pain management: American Pain Society Quality of Care Task Force. Arch Intern Med. 2005 Jul 25;165(14):1574-80. [82 references] [PubMed](#)

Gordon DB, Pellino TA, Miaskowski C, McNeill JA, Paice JA, Laferriere D, Bookbinder M. A 10-year review of quality improvement monitoring in pain management: recommendations for standardized outcome measures. Pain Manag Nurs. 2002 Dec;3(4):116-30. [57 references] [PubMed](#)

Green CR, Montague L, Hart-Johnson TA. Consistent and breakthrough pain in diverse advanced cancer patients: a longitudinal examination. J Pain Symptom Manage. 2009 May;37(5):831-47. [PubMed](#)

Mularski RA, White-Chu F, Overbay D, Miller L, Asch SM, Ganzini L. Measuring pain as the 5th vital sign does not improve quality of pain management. J Gen Intern Med. 2006 Jun;21(6):607-12. [PubMed](#)

Pletcher MJ, Kertesz SG, Kohn MA, Gonzales R. Trends in opioid prescribing by race/ethnicity for patients seeking care in US emergency departments. JAMA. 2008 Jan 2;299(1):70-8. [PubMed](#)

Reynolds K, Henderson M, Schulman A, Hanson LC. Needs of the dying in nursing homes. J Palliat Med. 2002 Dec;5(6):895-901. [PubMed](#)

University of North Carolina - Chapel Hill. National Quality Forum (NQF) measure submission and evaluation worksheet 5.0: Hospice and palliative care - pain assessment. 16 p.

Wells N, Pasero C, McCaffery M. Improving the quality of care through pain assessment and management. In: Hughes RG, editor(s). Patient safety and quality: An evidence-based handbook for nurses. Vol. 1. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2008.

Extent of Measure Testing

Reliability Testing

Data/Sample. Two research nurse abstractors independently recorded quality measures data on a random subset of 20 seriously ill patients. Abstractors used the pre-defined operational definitions and a structured chart abstraction tool to record numerator and denominator data separately. Patients were a subsample of 460 seriously ill patients without specialty palliative care admitted to an acute care hospital for at least 1 day to four inpatient services. Records eligible for sampling included all seriously ill adult patients admitted to medical and surgical intensive care, medically complex patients aged 65 and older admitted to an acute care of the elderly unit, and medical oncology patients with Stage IV carcinoma.

Analytic Method. Inter-rater reliability between the two abstractors was assessed using kappa statistics.

Testing Results. The nurse abstractors achieved excellent inter-rater reliability for this measure with Kappa=0.94.

Validity Testing

Data/Sample. Hospice: The total patient sample size was 126. Fourteen hospices, located in seven different states, representing both free-standing and hospital based providers were recruited to participate. Each hospice was asked to contribute data from nine patient records to the study. Nine hospices were asked to collect data on their most recent nine discharges; five hospices were asked to collect data on their most recent nine admissions.

Palliative Care: The total patient sample size was 562. Chart abstractions were completed for 102 consecutive seriously ill patients with specialty palliative care consultation, and a random sample of 460 seriously ill patients without specialty palliative care admitted to an acute care hospital for at least 1 day to four inpatient services with high proportions of seriously ill patients. Records eligible for sampling included all patients admitted to medical and surgical intensive care, medically complex patients aged 65 and older admitted to a geriatric evaluation unit, and medical oncology patients with Stage IV carcinoma. Because palliative care domains become even more relevant closer to death, patients dying in hospital were oversampled to ensure a final ratio of 1 decedent to 1 live discharge. Consistent with oversampling of decedent records, 55% of these patients died in hospital. The age of the patients ranged from 16 to 99 years, with the mean age 61. Patients were predominantly Caucasian (65%), with smaller subgroups who were African American (24%) and Hispanic/Latino (4%). The most common life-limiting diagnoses were infections (37%), cancer (34%), pulmonary (29%), and neurologic diseases (21%).

Analytic Method. Hospice sample: Face validity was tested using formal expert panel review. The PEACE project team convened a 14-member technical expert panel (TEP) of nationally recognized experts with extensive experience in the following areas: medical or nursing expertise in hospice and palliative care, methods and instrumentation, and quality improvement. Using criteria provided by the Carolinas Center for Medical Excellence (CCME) study team, TEP members rated each potential quality measure from 1 (low) to 5 (high) on four criteria: importance, scientific soundness, feasibility and usability. The rating criteria mirrored those used by the National Quality Forum and the Centers for Medicare & Medicaid Services (CMS) Measures Management System. To identify the measures with the most favorable ratings, a summary measure was created. For each quality measure, the average TEP rating for each criterion was calculated and then an overall average measure rating (AMR) was tabulated, weighting each the criteria equally.

Palliative Care sample: Face validity of PEACE quality measures for hospital-based specialty palliative care was addressed using stakeholder review and feedback. Investigators prepared data reports in a summary format with detailed operational definitions, and led a 1-hour discussion with nursing and physician leaders from each service group – medical intensive care unit (MICU), surgical intensive care unit (SICU), acute care for the elderly (geriatrics), oncology, and palliative care. The discussion included feedback of quality measure data, response to questions and critiques, and eliciting stakeholder feedback about the validity and actionability of this data for the care of their patients. Stakeholders were specifically asked to comment on the accuracy of the data as a reflection of current care practices, and their highest priority area for future quality improvement.

Construct validity was tested by comparing the PEACE quality measures for patients seen by specialty interdisciplinary palliative care consultants to those not receiving specialty palliative care services.

Testing Results. Hospice sample: Completed ratings were received from 13 of the 14 TEP members. The 75th percentile cut-point translated into an AMR=3.73 (on a scale of 1 to 5 where 5 is highest). This process resulted in the identification of 23 measures with the highest TEP ratings for importance, scientific soundness, feasibility and usability. Clinical assessment of pain had an overall rating of 4.15 while screening for pain was added as an antecedent measure. Pilot testing in the hospice sample revealed that only 78% of 126 hospice patients were screened for pain, and 60% of those who screened positive were given a comprehensive clinical assessment of their pain.

Palliative Care sample: Face Validity: Stakeholder discussions provided broad endorsement of face validity, with some considerations for specific patient populations. Intensive care and geriatrics clinicians endorsed the primary importance of pain screening and assessment, but expressed doubts about the validity of numerical pain severity ratings when used for nonverbal or confused patients. Medical oncologists endorsed the face validity of these quality measures, but favored quality measures endorsed by oncology professional organizations.

Construct Validity: Screening for pain with a numerical pain scale was nearly universal for all seriously ill patients, regardless of use of specialty palliative care, and half had moderate or severe pain. Patients with moderate or severe pain were more likely to have a clinical assessment of pain if seen by specialty palliative care (67% vs 42%, $p=0.002$).

Identification of Meaningful Differences in Performance

Data/Sample. Hospice: The total patient sample size was 126. Fourteen hospices, located in seven different states, representing both free-standing and hospital based providers, were recruited to participate. Each hospice was asked to contribute data from nine patient records to the study. Nine hospices were asked to collect data on their most recent nine discharges; five hospices were asked to collect data on their most recent nine admissions.

A common structured data collection tool was developed for use by all hospices, regardless of whether the patient record was an admission or discharge record. Instructions embedded in the tool indicated the data items appropriate to each type of record. Hospices were instructed not to institute new data collection procedures for the data collection pilot. If a data item could not be found, they were told to mark the item as "unable to determine."

A data dictionary containing item-specific instructions and notes related to the patient data collection tool was distributed to each hospice center. Technical assistance was provided by email and phone to staff during the data collection period. Questions, and responses, that arose during data collection were immediately distributed to all hospices participating in the data pilot.

Palliative Care: The total patient sample size was 562. Chart abstractions were completed for 102 consecutive seriously ill patients with specialty palliative care consultation, and a random sample of 460 seriously ill patients without specialty palliative care admitted to an acute care hospital for at least 1 day to four inpatient services with high proportions of seriously ill patients. Records eligible for sampling included all patients admitted to medical and surgical intensive care, medically complex patients aged 65 and older admitted to a geriatric evaluation unit, and medical oncology patients with Stage IV carcinoma. Because palliative care domains become even more relevant closer to death, patients dying in hospital were oversampled to ensure a final ratio of 1 decedent to 1 live discharge. Consistent with oversampling of decedent records, 55% of these patients died in hospital. The age of the patients ranged from 16 to 99 years, with the mean age 61. Patients were predominantly Caucasian (65%), with smaller subgroups who were African American (24%) and Hispanic/Latino (4%). The most common life-limiting diagnoses were infections (37%), cancer (34%), pulmonary (29%), and neurologic diseases (21%).

Analytic Method. Construct validity was tested by comparing the PEACE quality measures for patients seen by specialty interdisciplinary palliative care consultants to those not receiving specialty palliative care services. Percentage of patients with and without specialty palliative care for whom the quality

measure was met was compared for difference using the chi-square statistic.

Results. Hospice sample: 60% of patients who screened positive for pain on the admission evaluation had a comprehensive pain assessment within 24 hours.

Palliative Care sample: Patients with moderate or severe pain were more likely to have a documented clinical assessment of pain if seen by specialty palliative care (67% vs 42%, $p=0.002$).

Evidence for Extent of Measure Testing

Schenck AP, Rokoske FS, Durham DD, Cagle JG, Hanson LC. The PEACE Project: identification of quality measures for hospice and palliative care. *J Palliat Med.* 2010 Dec;13(12):1451-9. [PubMed](#)

University of North Carolina - Chapel Hill. National Quality Forum (NQF) measure submission and evaluation worksheet 5.0: Hospice and palliative care - pain assessment. 16 p.

State of Use of the Measure

State of Use

Current routine use

Current Use

not defined yet

Application of the Measure in its Current Use

Measurement Setting

Hospices

Hospital Inpatient

Professionals Involved in Delivery of Health Services

not defined yet

Least Aggregated Level of Services Delivery Addressed

Single Health Care Delivery or Public Health Organizations

Statement of Acceptable Minimum Sample Size

Specified

Target Population Age

Adult & elderly

Target Population Gender

Either male or female

National Strategy for Quality Improvement in Health Care

National Quality Strategy Aim

Better Care

National Quality Strategy Priority

Person- and Family-centered Care

Prevention and Treatment of Leading Causes of Mortality

Institute of Medicine (IOM) National Health Care Quality Report Categories

IOM Care Need

End of Life Care

Living with Illness

IOM Domain

Effectiveness

Patient-centeredness

Timeliness

Data Collection for the Measure

Case Finding Period

Unspecified

Denominator Sampling Frame

Patients associated with provider

Denominator (Index) Event or Characteristic

Diagnostic Evaluation

Institutionalization

Therapeutic Intervention

Denominator Time Window

not defined yet

Denominator Inclusions/Exclusions

Inclusions

Patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting who report pain when pain screening is done on the admission evaluation/initial encounter

Note:

This quality measure is intended for patients with serious illness who are enrolled in hospice care OR receive specialty palliative care in an acute hospital setting. Conditions may include, but are not limited to: cancer, heart disease, pulmonary disease, dementia and other progressive neurodegenerative diseases, stroke, HIV/AIDS, and advanced renal or hepatic failure.

For patients enrolled in hospice, a positive screen is indicated by any pain noted in screening (any response other than none on verbal scale, any number greater than 0 on numerical scale or any observation or self-report of pain), due to the primacy of pain control and comfort care goals in hospice care.

For patients receiving specialty palliative care, a positive screen is indicated by moderate or severe pain noted in screening (response of moderate or severe on verbal scale, greater than 4 on a 10-point numerical scale, or any observation or self-report of moderate to severe pain). Only management of moderate or severe pain is targeted for palliative care patients, who have more diverse care goals. Individual clinicians and patients may still decide to assess mild pain, but this subset of patients is not included in the quality measure denominator.

Exclusions

Patients with length of stay less than 1 day in palliative care. Patients who screen negative for pain are excluded from the denominator.

Note: Calculation of length of stay: discharge date is identical to date of initial encounter

Exclusions/Exceptions

not defined yet

Numerator Inclusions/Exclusions

Inclusions

Patients who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain

Note: Patients with a comprehensive clinical assessment including at least 5 of the following 7 characteristics of the pain: location, severity, character, duration, frequency, what relieves or worsens the pain, and the effect on function or quality of life.

Exclusions

Unspecified

Numerator Search Strategy

Institutionalization

Data Source

Electronic health/medical record

Type of Health State

Does not apply to this measure

Instruments Used and/or Associated with the Measure

Patient Data Collection Tool for Recommended Quality Measures

Computation of the Measure

Measure Specifies Disaggregation

Does not apply to this measure

Scoring

Rate/Proportion

Interpretation of Score

Desired value is a higher score

Allowance for Patient or Population Factors

not defined yet

Standard of Comparison

not defined yet

Identifying Information

Original Title

Hospice and palliative care -- pain assessment.

Measure Collection Name

Palliative Care and End-of-Life Care

Submitter

University of North Carolina at Chapel Hill - Academic Institution

Developer

Carolinas Center for Medical Excellence - Nonprofit Organization

University of North Carolina at Chapel Hill - Academic Institution

Funding Source(s)

Centers for Medicare and Medicaid Services

Composition of the Group that Developed the Measure

The Carolinas Center for Medical Excellence (CCME) PEACE Project Technical Expert Panel (TEP)

The PEACE project team convened a 14-member TEP of nationally recognized experts with extensive experience in the following areas: medical or nursing expertise in hospice and palliative care, methods and instrumentation, and quality improvement. Using criteria provided by the CCME study team, TEP members rated each potential quality measure on four criteria: importance, scientific soundness, feasibility and usability.

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Financial Disclosures/Other Potential Conflicts of Interest

Unspecified

Endorser

National Quality Forum - None

NQF Number

not defined yet

Date of Endorsement

2016 Oct 26

Adaptation

This measure was not adapted from another source.

Date of Most Current Version in NQMC

2016 Dec

Measure Maintenance

3 years or as required

Date of Next Anticipated Revision

Unspecified

Measure Status

This is the current release of the measure.

This measure updates the following previous versions:

The Carolinas Center for Medical Excellence (CCME). Specifications for recommended quality measures. Cary (NC): The Carolinas Center for Medical Excellence (CCME); 8 p.
University of North Carolina – Chapel Hill. National Quality Forum (NQF) measure submission and evaluation worksheet 5.0: Hospice and palliative care – pain assessment. 16 p.

Measure Availability

Source available from the [University of North Carolina \(UNC\) School of Medicine Web site](#)

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Companion Documents

The following are available:

Assessment instruments for end of life care, by domain. Cary (NC): The Carolinas Center for Medical Excellence (CCME); 7 p. This document is available from the [University of North Carolina \(UNC\) School of Medicine Web site](#) .

Organizational readiness screen. Cary (NC): The Carolinas Center for Medical Excellence (CCME); 4 p. This document is available from the [UNC School of Medicine Web site](#) .

Patient data collection tool for recommended quality measures. Cary (NC): The Carolinas Center for Medical Excellence (CCME); 7 p. This document is available from the [UNC School of Medicine Web site](#) .

"Read this first": getting started with PEACE quality measures. Cary (NC): The Carolinas Center for Medical Excellence (CCME); 3 p. This document is available from the [UNC School of Medicine Web site](#) .

Recommended quality measures and data collection, by domain. Cary (NC): The Carolinas Center for Medical Excellence (CCME); 3 p. This document is available from the [UNC School of Medicine Web site](#) .

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NQMC Status

This NQMC summary was completed by ECRI Institute on July 19, 2013. The information was verified by the measure developer on September 5, 2013.

This NQMC summary was updated by ECRI Institute on February 7, 2017. The information was not verified by the measure developer.

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No copyright restrictions apply.

Production

Source(s)

National Quality Forum (NQF). Palliative and end-of-life care 2015-2016: technical report. Washington (DC): National Quality Forum (NQF); 2016 Dec 23. 209 p.

The Carolinas Center for Medical Excellence (CCME). Specifications for recommended quality measures. Cary (NC): The Carolinas Center for Medical Excellence (CCME); 8 p.

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